TwelveStone Health Partners
Fax Referral To: (615) 278-3355
Direct Phone: (844) 893-0012
Email: intake@12stonehealth.com

KEYTRUDA ORDER FORM

Date: _____

Patient Name: _____

Date of Birth: _____

ICD-10 Code: _____

Allergies: _____

Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start
Previous Therapy: _____
Date of Last Dose: _____
Wash Out Period: _____

☐ Continuing Therapy:
Last Dose: _____

Provider Information

Ordering Provider: _____
Provider NPI: _____
Provider Phone: _____
Provider Fax: _____
Provider Address: _____

MEDICATION ORDER

Keytruda
To be given as a Monotherapy

☐ 200mg every 3 weeks
☐ 400mg every 6 weeks

Refills for one year from date of signature unless indicated below.

_____ Refills

Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:

✓ Liver Enzymes (AST/ALT), creatinine, and thyroid function within the past 60 days

PRE-MEDICATIONS

Oral

☐ Acetaminophen: _____ 325mg _____ 500mg _____650mg
☐ Loratadine: 10mg
☐ Cetirizine: 10mg
☐ Diphenhydramine: _____ 25mg _____ 50mg
☐ Famotidine: _____ 20mg _____ 40mg
☐ Ibuprofen: _____ 200mg _____ 400mg _____ 600mg
☐ Ondansetron: _____ 4mg _____ 8mg
☐ Other: _____

IV

☐ Dexamethasone: _____ 4mg _____ 8mg
☐ Diphenhydramine: _____ 25mg _____ 50mg
☐ Famotidine: _____ 20mg _____ 40mg
☐ Methylprednisolone: _____ 125mg
☐ Hydrocortisone: _____ 100mg
☐ Ondansetron: _____ 4mg _____ 8mg
☐ Other: _____

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature *(SIGN BELOW)*

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

Dispense as Written:

_____ _____
Prescriber Signature Date

Substitution Allowed:

_____ _____
Prescriber Signature Date